

Slide 1: Discussion 1: When Conventional Wisdom, Clinical Policy/Practice, and Evidence Collide

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Slide 2: U.S. Preventive Services Task Force Mammography Recommendations: 2002 Versus 2009

- 2002
 - B: Mammography, with or without clinical breast examination (CBE), every 1 to 2 years for women age 40 and older
 - I: CBE alone
 - I: Teaching/performing routine breast self-examination (BSE)
- 2009
 - B: Mammography every 1 to 2 years for women age 50 to 74
 - C: Mammography every 1 to 2 years for women age 40 to 49
 - I: Mammography for women age 75 and older
 - I: CBE alone
 - D: Teaching BSE
 - I: Digital mammography or magnetic resonance imaging instead of film mammography

Slide 3:

“The USPSTF [U.S. Preventive Services Task Force] recommends against routine screening mammography in women aged 40 to 49 years. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.”

Slide 4: U.S. Preventive Services Task Force: Historical Perspective — A 1997 Controversy

The controversy was highlighted in this article:

Kolata G. Stand on mammograms greeted by outrage. New York Times 1997 Jan 28.

Slide 5: U.S. Preventive Services Task Force: Historical Perspective — A 1987 Controversy

The controversy was highlighted in this article:

Brozan N. How effective is breast self-examination? New York Times 1987 May 4.

Excerpt:

“Many members of the public were confused by the report.”

“‘It was a shame that the report was ever published, and I think the public ought to ignore the findings,’ said Dr. Charles R. Smart, chief of the early detection

branch, division of cancer prevention and control, of the National Cancer Institute in Bethesda, Md.”

Slide 6: Discussion Topics: Why Does Conventional Wisdom Hold Sway for Patients?

- Are facts the answer to unrealistic expectations?
- What fuels unrealistic expectations and outdated beliefs?
 - Scientific illiteracy, unawareness of downsides?
 - Poor communication?
 - Common sense (“no-brainers”)?
 - Emotions and fears?
 - Personal experiences? Brand loyalty?
 - What family and friends do or recommend?
 - What I [the patient] have always done?
 - What guidelines have always been recommended?
 - Slick advertising?
- What suspicions arise when doctors or guidelines challenge beliefs?
- How can the argument be reframed to meet patients where they are?

Slide 7: U.S. Preventive Services Task Force: Reaction to the 2009 Mammography Controversy (1 of 2)

- As portrayed by media, a new “federal panel” had:
 - Recommended against mammography for women between the ages of 40 and 49, despite evidence that it saved lives
 - Had advised against women self-examining their breasts, the method by which most types of breast cancer are detected
- The panel was condemned by medical organizations, breast cancer experts, and women’s groups.
- Experts discredited the panel, pointing out that that it:
 - Did not include radiologists or oncologists
 - Relied on mathematical models rather than outcomes data

Slide 8: U.S. Preventive Services Task Force: Reaction to the 2009 Mammography Controversy (2 of 2)

- The potential harms of screening were characterized as ridiculous and a subterfuge for cost-cutting.
- The U.S. Preventive Services Task Force (USPSTF) was accused of working at the behest of insurance companies.
- Critics warned that payers might reduce mammography coverage.
- A media frenzy—newspapers, network news, talk shows, and blogs—fueled the controversy.
- USPSTF members received hostile emails.

- The U.S. Department of Health and Human Services distanced itself; Secretary Katherine Sebelius issued clarifying statement.

Slide 9: Discussion Topics: Why Does Conventional Wisdom Hold Sway for Clinicians?

- Are clinicians immune to unrealistic expectations?
- What are the roles of training and standards of care in petrifying conventional wisdom?
- How does clinical experience and the selection bias of referred populations reinforce conventional wisdom and “refute” the evidence?
- Do medicolegal concerns protect conventional wisdom?
- Are there financial or other incentives, such as market demand or patient expectations, to cling to conventional wisdom?
- How can the argument be reframed to meet clinicians where they are?

Slide 10: Discussion Topics: Why Does Conventional Wisdom Hold Sway for Policymakers?

- Can facts overcome unrealistic expectations?
- What other factors work against change?
 - Popular misconceptions?
 - The inability to explain facts through sound bites?
 - The incentives to tell people what they want to hear?
 - Constituents?
 - Special interests and political agendas?
 - Profits, ratings, and other industry motives?
 - The special interests of medical specialties?
- How can the argument be reframed to meet policymakers or the media where they are?